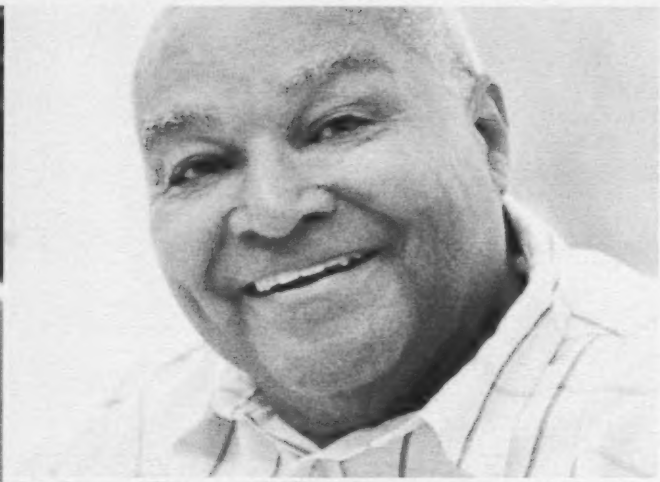
Waterloo Wellington **LHIN**

COMMUNITY REPORT 2015-16

Ontario
Local Health Integration Network



OUR MISSION IS: To lead a high-quality integrated health system for our residents.

OUR VISION IS: Better Health – Better Futures.

OUR CORE VALUE IS: Acting in the best interest of our residents' health and well-being.

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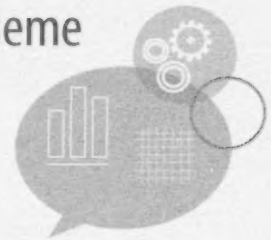
"When we look at the magnitude of our collective accomplishments, one theme stands out: Innovation."



LETTER FROM CEO/CHAIR

The past year marked the completion of the 2013-16 Integrated Health Service Plan (IHSP), an ambitious three-year plan for local health care that resulted in significant changes to how services are organized and delivered.

Three years ago most of our health programs in hospitals operated independently of one another, today they are led by integrated clinical program councils to ensure the same high-quality care is provided as efficiently as possible from Southgate to North Dumfries. As a result, we have the most improved stroke program in the province. More residents are surviving and thriving after a heart attack. People in Waterloo Wellington are among the least likely in all of Ontario to need to be readmitted to hospital for care following a hospital stay and spent almost 40,000 fewer days in hospital waiting for care in a more appropriate place.

Waterloo Wellington is also home to several first-in-Ontario programs such as HERE 24/7, Mobile Crisis Teams and Connectivity tables. These programs bring together resources from across public service and health agencies to support the well-being of residents beyond just health care to better address the social determinants of health.

When we look at the magnitude of our collective accomplishments, one theme stands out: Innovation.

Waterloo Wellington is a hub of innovation. While known for its "Silicon Valley of the North" technology sector, innovation in our local community is so much more. It's innovation through leadership – community leaders in health, justice, business, social services, municipalities, etc., stepping up to advocate for the advancement of our community. Innovation through collaboration – organizations coming together and reaching outside of their traditional roles. Innovation through research – capitalizing on world-class educational institutions to apply best-practices to direct patient care. And of course, innovation through technology – utilizing enabling technologies to better connect community needs with community services.

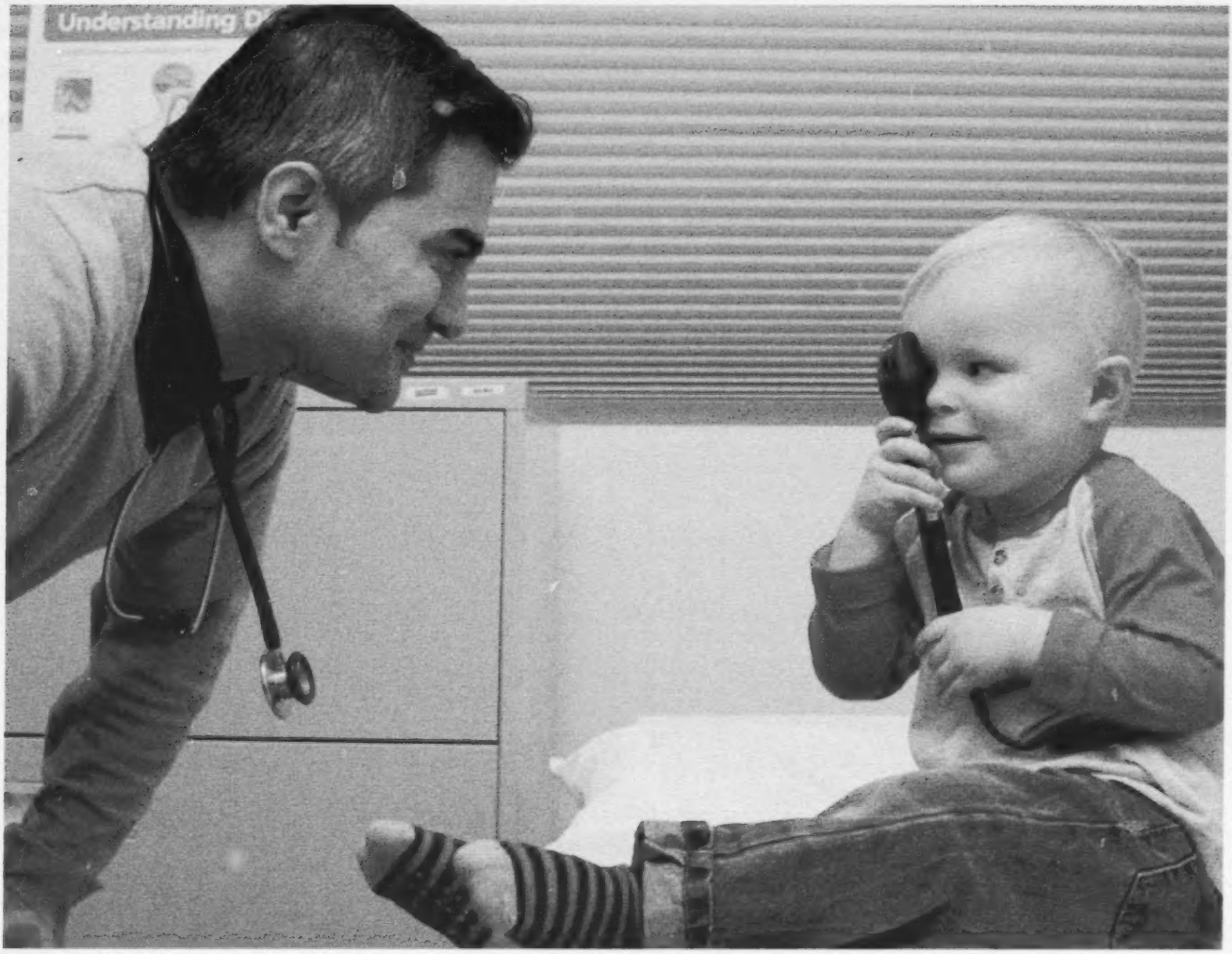
While we have continued to invest significantly in local health care, $300 million more today than almost 10 years ago, the most significant improvements in care have been made through innovation.

This Community Report shares highlights of the major innovations this year across the health system - through collaboration and partnership with our local health service providers, governors and community leaders – to deliver a high-quality, integrated health system for local residents. In the middle, you will also find a timeline of how your local health care improved over the duration of the last three-year IHSP.

We would like to thank all of our local health professionals for their tremendous work each day to provide the best possible care for our residents. We look forward to sharing more stories and updates with you throughout the year as we continue to innovate to improve the health and well-being of each and every resident across Waterloo Wellington.

Bruce Lauckner,
CEO

Joan Fisk,
Chair, Board of Directors



WHO WE ARE

The Waterloo Wellington Local Health Integration Network (Waterloo Wellington LHIN) is responsible for designing, funding and overseeing the performance of the health system for the almost 800,000 people who live in Waterloo Region, the City of Guelph, Wellington County and the southern part of Grey County.

We work with residents, families, health service providers, community organizations, local government and other community partners to build a better health care system for everyone in Waterloo Wellington. We are passionate about putting residents first in everything we do.

We listen, we build partnerships, we act, and we lead, and we do it all together with dedicated health care professionals across the system.

WWLHIN's TOTAL POPULATION
778,676

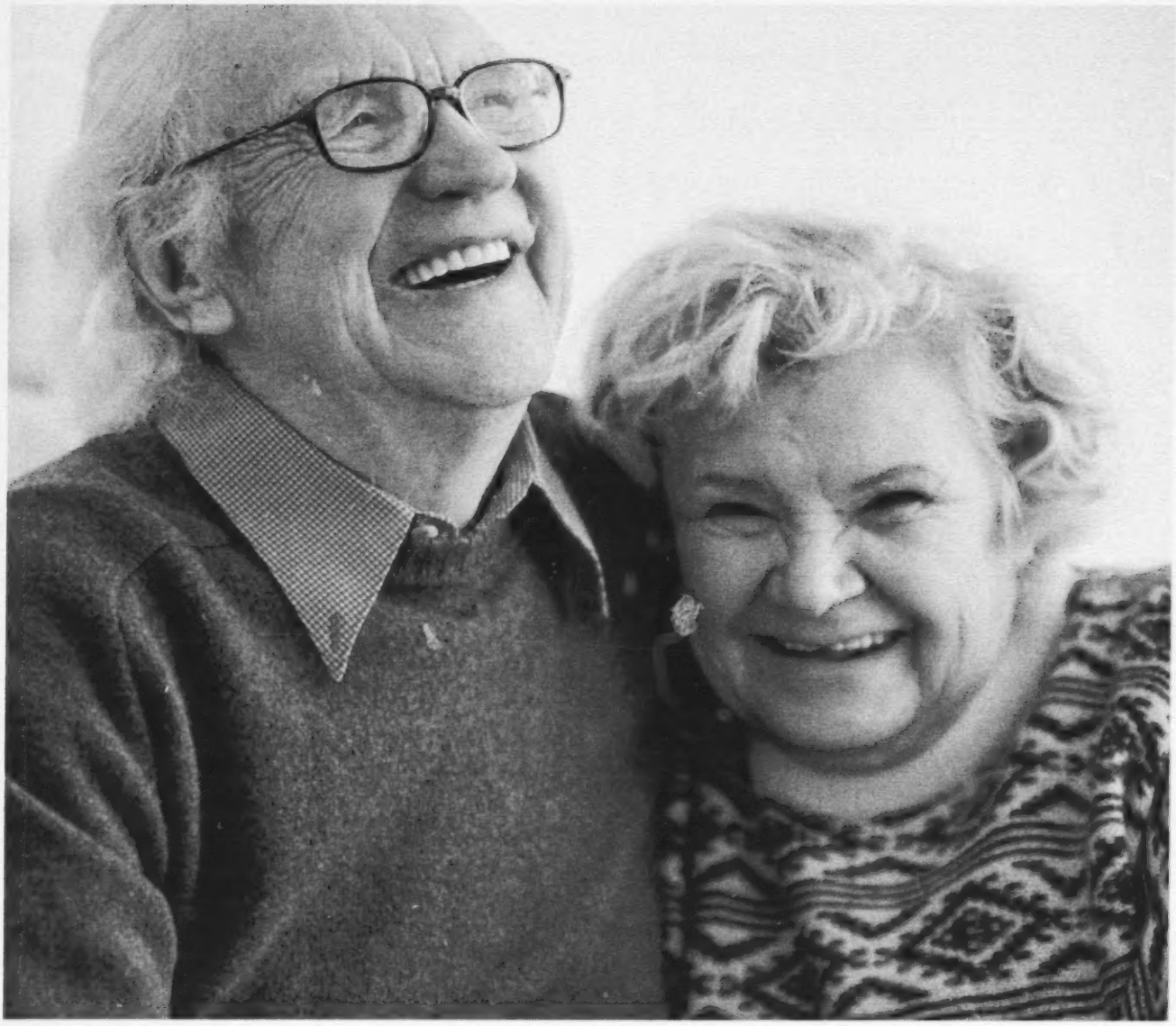
SENIORS (65 YEARS & OLDER)
14.3%

FRANCOPHONE POPULATION
12,000

ABORIGINAL POPULATION
10,000

RURAL AREA POPULATION
11%

IMMIGRANT POPULATION
20.5%



A ROADMAP FOR IMPROVING LOCAL HEALTH

Every three years, we engage with local residents, health service providers and other community leaders to create a strategic plan that outlines what health services matter most to local residents. That plan, the Integrated Health Service Plan (IHSP), is the roadmap for improving the local health system over the following three years.

The following pages provide an overview of the key initiatives undertaken this year in the priority areas of:

- Enhancing Access to Primary Care;
- Creating a More Seamless and Coordinated Health Care Experience; and
- Leading a Quality Health Care System Using Evidence Based Practice.

This report also includes stories from residents to tell you how local health system improvements have positively affected their health and well-being. We are fortunate to interact with residents each and every day and believe that the true impact of our work is best seen through their stories.

ENHANCING ACCESS TO PRIMARY CARE

Your primary care provider is probably the first health care professional you will turn to for care. Primary care professionals are often family doctors but they may also be nurse practitioners or other health care professionals who support your day-to-day care and are responsible for coordinating any services that you may need from other providers or specialists.

For primary care providers across the Waterloo Wellington LHIN to deliver the best care possible, it is important that they are well informed, connected with other health service providers and have access to technology that will assist them in providing the best care.

This year, we put great focus on enhancing access to primary care for our most vulnerable residents – those with complex medical needs and those from populations that are marginalized or at risk for poor health outcomes.

IN 2015-16...

2nd

among Ontario LHINS for the lowest overall hospital readmission rates for patients with chronic conditions (a measure of high quality care).

62%

of residents report that their primary care provider always discusses care options and includes them in medical decisions, an increase of 9%.

170

residents received wrap-around social supports through Connectivity Tables; an international award winning partnership that better supports residents at risk.

34,000

virtual care visits provided in Waterloo Wellington in 2015-16, bringing care close to home through video conferencing for many residents who have difficulty traveling to see their doctor.

"It was so well organized; all of the health care providers were amazing and worked very well together, even though they were all from different places. They went beyond their job to help people feel comfortable."

- Doha Shahin, an Arabic interpreter with the KW Multicultural Centre.

FROM DESPAIR TO HOPE: CONNECTING REFUGEES TO PRIMARY CARE

As part of Canada's commitment to resettle 25,000 Syrian refugees, the Waterloo Wellington LHIN led the local health care response to ensure families arriving in Waterloo Wellington from Syria would have access to the vital health services they need. Working in partnership with public health, primary care, education, hospitals, community organizations and local municipalities, a number of innovative initiatives were launched collaboratively to welcome these new families and help them navigate local services.

"Overall, the health of Syrian newcomers was generally good but many had not had regular health and dental care or immunizations for years due to the Syrian civil war and the difficulties that come with living in refugee camps," explained Lisa Bitonti-Bengert, Senior Manager, Health System Integration. "Additionally, many were impacted by emotional trauma as a result of experiencing the violent conflict that comes with war."

Primary Care Registered Nurses from Sanctuary Refugee Health Centre were deployed to the Refugee Assistance Program Centre in Kitchener to triage reported health concerns and provide health teaching to prevent unnecessary visits to the Emergency Department (ED). Public health held on-site immunization clinics. Service Ontario provided on-site OHIP card registrations. As new residents began to arrive

More than 1,200 Syrian refugees have settled in Waterloo Region since late 2015. Over the next five years, we anticipate the arrival of up to 3,500 more refugees from Syria and other countries to settle in Waterloo Wellington.

quickly, it was evident that the need for faster access to primary care was vital but in an organized way that would support their transportation, housing, translation and cultural realities to ensure the care provided was thoughtful and effective.

"Together we came up with the idea of clinic days where newcomer families could receive their initial health assessments, necessary medications, any referrals to other services they might need and be connected to a more permanent primary care provider all in one visit," said Lisa.

Many partners came to the table to organize the clinic, including: the Mount Forest Family Health Team, the Centre for Family Medicine Family Health Team, the Woolwich Community Health Centre, the KW Multicultural Centre, LifeLabs, and Waterloo Region and Wellington Dufferin Guelph Public Health. Grand River Transit also provided free transportation for refugees and their families to and from the clinic.

"So many organizations partnered to make this happen," explains Lisa. "Several family and emergency room doctors, nursing staff, volunteers, a pharmacist, and interpreters from all over participated to support this work. In all, there were three weekend clinic days that cared for 198 people. It was a tremendous success that connected an extremely vulnerable population to the care they needed quickly, and reduced the need for them to seek care in emergency departments and urgent care clinics."

"It was so well organized; all of the health care providers were amazing and worked very well together, even though they were all from different places. They went beyond their job to help people feel comfortable. Some learned some greeting words in Arabic so that they could say hello, goodbye, and great job. We, as interpreters, thought it would be chaotic due to the large numbers of clients, but it really wasn't. We were all impressed! Although the new clients had seen a lot of sadness, there were some happy stories in these clinics. One woman, for example, had two sons, the youngest 11 and has been trying for nine years to have another baby. She was tested at the clinic and it turned out that she had gotten pregnant during her first month in Canada. She was thrilled – over the moon to have a Canadian baby!"

- Doha Shahin, an Arabic interpreter with the KW Multicultural Centre.

"We've recognized that when people come to live in a new country where the culture and language are different, using public transit can be intimidating. So, we provide travel training and can arrange tours for newcomers to show them the bus routes, community resources, how to use tickets and transfers and hopefully, make it a more pleasant experience to foster independence. Helping new residents get to the clinic seemed like a great way to support them. One of the drivers involved told me afterwards that it was a really positive experience."

- Dave Steffler, training specialist, Grand River Transit

"First, we opened access to all of our wellness classes and groups to patients of family doctors who didn't have these additional supports." - Ross Kirkconnell, Executive Director, Guelph FHT

Provider and patient in a Guelph FHT office.

2,200 residents who have complex medical and social needs have a care plan outlining their health and wellness goals that is shared with their primary care provider and care team.

THEN (2012)

64% of residents had a primary care provider

NOW (2016)

97% of residents have a primary care provider

IMPROVED ACCESS TO COMPREHENSIVE PRIMARY CARE FOR GUELPH RESIDENTS

Close to 15,000 more Guelph residents are now able to access health and wellness supports they didn't have before thanks to a decision made in early 2016 by the Board of the Guelph Family Health Team (FHT).

"When the Guelph FHT started, we had 33 family doctors and about 40,000 patients," explains Ross Kirkconnell, the Family Health Team's Executive Director. "We would repeatedly hear from patients whose doctors were not in our team that they wanted access to the supports we have. It was evident that we needed to look at ways to provide – as much as possible – equitable access to available health services for all residents to really improve the health of our population."

There are many different models of primary care in Ontario. Some family doctors work on their own to provide care while some work in groups. Family Health Teams, like the Guelph FHT, use teams with a variety of health professionals that include family doctors in addition to other support services including dietitians, mental health counsellors and social workers. But while the Guelph FHT's 40,000 patients were able to access these vital health and wellness services, many other Guelph residents could not.

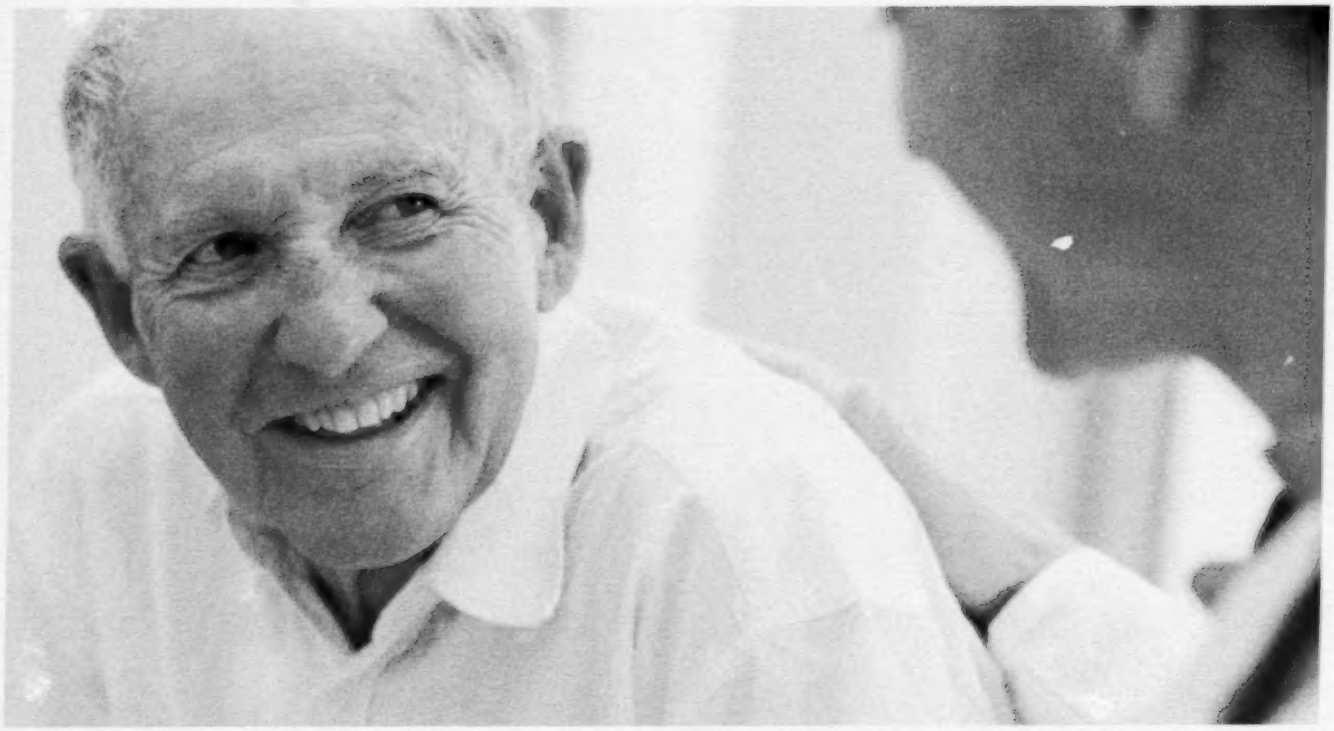
Over the years, the Guelph FHT expanded to 115,000 patients, 80 family physicians and more than 200 staff in 25 locations in Guelph. Between the Guelph FHT and the Guelph Community Health Centre, about 90 per cent of Guelph residents had access to comprehensive team-based care. The Guelph FHT Board saw the need and opportunity to be even more inclusive. So they researched models of care that exist outside of Ontario that allow for the integration and collaboration of health services across care providers to better support the health needs of an entire population.

With the guiding principle that all patients who have complex needs can benefit from this type of care, whether their primary care providers are part of the family health team or not, this comprehensive care was made available to anyone in need in the community.

"First, we opened access to all of our wellness classes and groups to patients of family doctors who didn't have these additional supports," explains Ross. "We are now meeting with these doctors to better understand the needs of their patients and ensure that we can support their work through access to our interdisciplinary team services."

Staff at the Guelph FHT are continuing to work with area family doctors, practice by practice, to embed additional supports for their patients.

"So far feedback is very positive," says Ross. "I have heard stories of couples where one spouse belonged to the Family Health Team while the other did not. The spouse who was not with the team often felt like they weren't getting the same support. And feedback from physicians has repeatedly indicated that sharing these services creates an equitable outcome for everyone with a real focus on helping their patients, especially those with complex situations and chronic diseases."



To achieve our objective of enhancing access to primary care, the following initiatives were undertaken with health professionals across Waterloo Wellington:

ESTABLISH FAMILY HEALTH CARE AS THE HUB OF THE HEALTH CARE SYSTEM TO IMPROVE YOUR ACCESS TO SERVICES AND POSITIVE HEALTH OUTCOMES.

HEALTH LINKS

INITIATIVE

- Build on the four Waterloo Wellington Health Links to improve coordinated access to care for residents with complex health needs.
- Ensure residents with complex health needs have access to primary care.

ACCOMPLISHMENT

- 2,200 residents with complex medical and social needs have a care plan outlining their health and wellness goals that is shared with their primary care provider and care team.
- A pilot project to make these care plans available online was completed so that residents, their family and their care team can see the care plan and update it.
- 100% of residents who have complex medical needs have a primary care provider

SOCIAL DETERMINANTS & COLLABORATION OUTSIDE OF HEALTH CARE

INITIATIVE

- Continue to grow partnerships amongst and between health, housing, social services, education, justice, and other community partners to improve population health.
- Identify more effective support for those at risk in our community through efforts such as Connectivity/Situation Tables.

ACCOMPLISHMENT

- 1,250 Syrian Refugees were welcomed and connected to medical care, housing, education, social services, public health, and local transit.
- Four connectivity tables are now in place so all residents in Waterloo Wellington LHIN have access to this wrap around multi-sector support. Two of these four tables were newly developed this year.
- 170 resident situations were supported by Connectivity Tables preventing crime, suicide, school drop outs and homelessness. An evaluation showed a 74% reduction in calls for police services within 90 days of resolution.

"Practicing for over a decade, I am aware that is difficult for health care providers and patients to "navigate the system". Central intake has allowed us to get the RIGHT care at the RIGHT time for the RIGHT patient at the RIGHT location. Central Intake has been effective, efficient and easy for ALL to use!!" - Endocrinologist, Waterloo

IMPROVE TIMELY ACCESS TO PRIMARY CARE.

ACCESS TO CARE CLOSE TO HOME/ENABLING TECHNOLOGIES INITIATIVE

- Review and optimize use of telemedicine and tele-homecare.

ACCOMPLISHMENT

- More than half of long-term care homes are ready to access virtual (secure video conference) primary and specialist care.
- 27,000 virtual care visits were provided to residents so they did not need to travel outside of their home town to see a specialist. 75% of these visits were for supports related to mental health and addiction needs.
- 6,700 virtual care visits of the 27,000 were done using mobile devices (hand-held or laptop) as opposed to stationary units in organizations.
- 3,000 virtual education events were held for residents and Health Care providers. Events included support groups, self-care education sessions. Virtual care visits and education sessions are now being delivered through mobile devices.
- 337 residents received innovative end-of-life care in their homes through a tele-homecare program called "e-shift". A nurse monitors patients 24 hrs a day/7 days a week virtually and care is provided by specially trained Personal Support Workers so residents and families are well supported.

DEVELOP AND IMPLEMENT A MODEL FOR COMMUNITY-BASED CHRONIC DISEASE PREVENTION AND MANAGEMENT.

CHRONIC DISEASE PREVENTION & MANAGEMENT & DIABETES INITIATIVE

- Improve access and best practice guidelines for diabetes care and chronic disease prevention and management focused on congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

ACCOMPLISHMENT

- Residents in Waterloo Wellington are among the least likely in Ontario to be readmitted to hospital after discharge for a chronic condition (e.g. diabetes, chronic obstructive pulmonary disease (COPD)).
- Diabetes adult education programs worked with 11,285 patients with diabetes in 2015-16 providing nearly 38,000 clinical interactions for these patients.
- The average wait time for access to diabetes care was as long as 16 weeks only a few years ago. In 2015-16, patients with an urgent referral were seen on average in 2 days, semi-urgent in 8.6 days and non-urgent in 16.8 days – all within the provincial targets.
- Stroke/TIA (warning stroke) patients treated on a specialized stroke unit at any time during their inpatient stay improved from 62.8% to 75.9% - best in Ontario.
- The Waterloo Wellington LHIN achieved the highest proportion of patients in the province admitted to inpatient rehabilitation with severe strokes, increasing from 42.1% to 54.7%.
- 978 residents were supported through the Integrated Comprehensive Care discharge model from St. Mary's General Hospital contributing to significant reductions in emergency visits and hospital readmissions for patients with COPD and CHF (Chronic Heart Failure). This innovative program is the 2nd of its kind in Ontario.

There are 147 additional practicing family doctors and specialists in Waterloo Wellington since 2010.

IMPROVE TIMELY INFORMATION SHARING BETWEEN PRIMARY CARE AND OTHER PROVIDERS.

SYSTEM COORDINATED ACCESS/ENABLING TECHNOLOGIES INITIATIVE

- Build and enhance a technology solution to provide coordinated access to health services including Community Support Services, Rehabilitative Care, Palliative/End of Life Care, Mental Health and Addictions services and Diabetes Education through the System Coordinated Access project.
- Support primary care through technology to ensure coordinated, equitable, informed access to specialist care and explore options for shared care planning.

ACCOMPLISHMENT

- We have innovated a one-of-a-kind referral system that helps connect residents to services more quickly and efficiently through their primary care provider and care team. Successes to date:
  - 6,231 residents with diabetes were referred for diabetes care through central intake, an 11% increase from the previous year, including 302 self-referrals which increased 27% from 2014-15.
  - 1,269 resident referrals were made to diabetic specialists through central intake.
  - 4,886 residents were referred to a number of programs and services, including meals on wheels, transportation, housekeeping, Adult Day Programs and more.

IMPROVE ACCESS TO APPROPRIATE CARDIAC CARE.

INITIATIVE

Improve access to appropriate levels of congestive heart failure care (CHF) in community, primary and acute care settings.

ACCOMPLISHMENT

- New Vision Family Health Team implemented a new program for residents who suffer from congestive heart failure (CHF). This primary care based model allows patients to receive care closer to home.

Residents can now self-refer online to access more than 285+ programs to help them prevent and manage chronic diseases at www.wwselfmanagement.ca. A coordinated online referral has also been developed for primary care so they can quickly help their patients get connected to these supports.

The Bosch Foundation Tour Guests at Woolwich SHC

"What you have here is what we have been dreaming about in Germany."

- Pediatrician, guest of The Bosch Foundation touring Waterloo Wellington to learn about best practice primary care in Canada

SYSTEM COORDINATED ACCESS

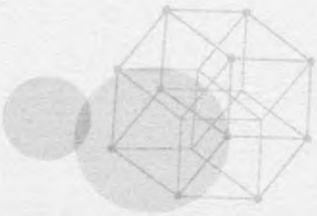
A lot of work is happening in Waterloo Wellington to embed enabling technology solutions within the local health system to support better, timely and more equitable care for residents. Enabling technologies are information and clinical technologies that are used to improve health care.

It means we're working to develop innovative technology solutions that will support care providers and improve patient care by reducing errors, better connecting care providers with each other and patients, improving communication and allowing patients to play a more significant role in their own health.

In late 2015, the Waterloo Wellington LHIN Board of Directors approved an investment of up to $250,000 in funding for the development and implementation of a System Coordinated Access tool for primary care providers to refer their patients to area specialists, starting with orthopaedic surgeons (hip and knee surgery).

This will allow primary care providers to locate area surgeons, view their wait times and share information to support the care of patients together, all securely on-line. This will also allow patients to choose the surgeon and location that works best for them.

From electronic medical records, used by nearly 90% of local primary care providers, to hospital report manager, a system that allows hospitals to seamlessly update the electronic medical records of patients they share with local primary care providers, enabling technologies are changing the way that health care is accessed and delivered in Waterloo Wellington.



CONNECTING CARE, PATIENTS AND THEIR LOVED ONES THROUGH HEALTH CARE TECHNOLOGY

As Cancer Care Coordinator with the Mount Forest Family Health Team, Carol's role often involves meeting with patients and their families to provide support and help them navigate on their journey through the health system.

"My day-to-day tasks change a lot depending on the needs of the patient and family," explains Carol. "Sometimes I provide more support for the family than the patient. Recently I supported a family, Kevin who had been diagnosed with late-stage cancer and his wife Linda. I started by visiting them in their home to provide emotional support and practical help but it wasn't long before Kevin had to be admitted to the hospital for more intense round-the-clock care."

Kevin was transferred to hospital and then to long-term care at St. Joseph's Health Centre in Guelph to receive end-of-life care. The transition from hospital to long-term care was difficult for both Kevin and his family; St. Joseph's Health Centre was the right place for him to be but was far from his home.

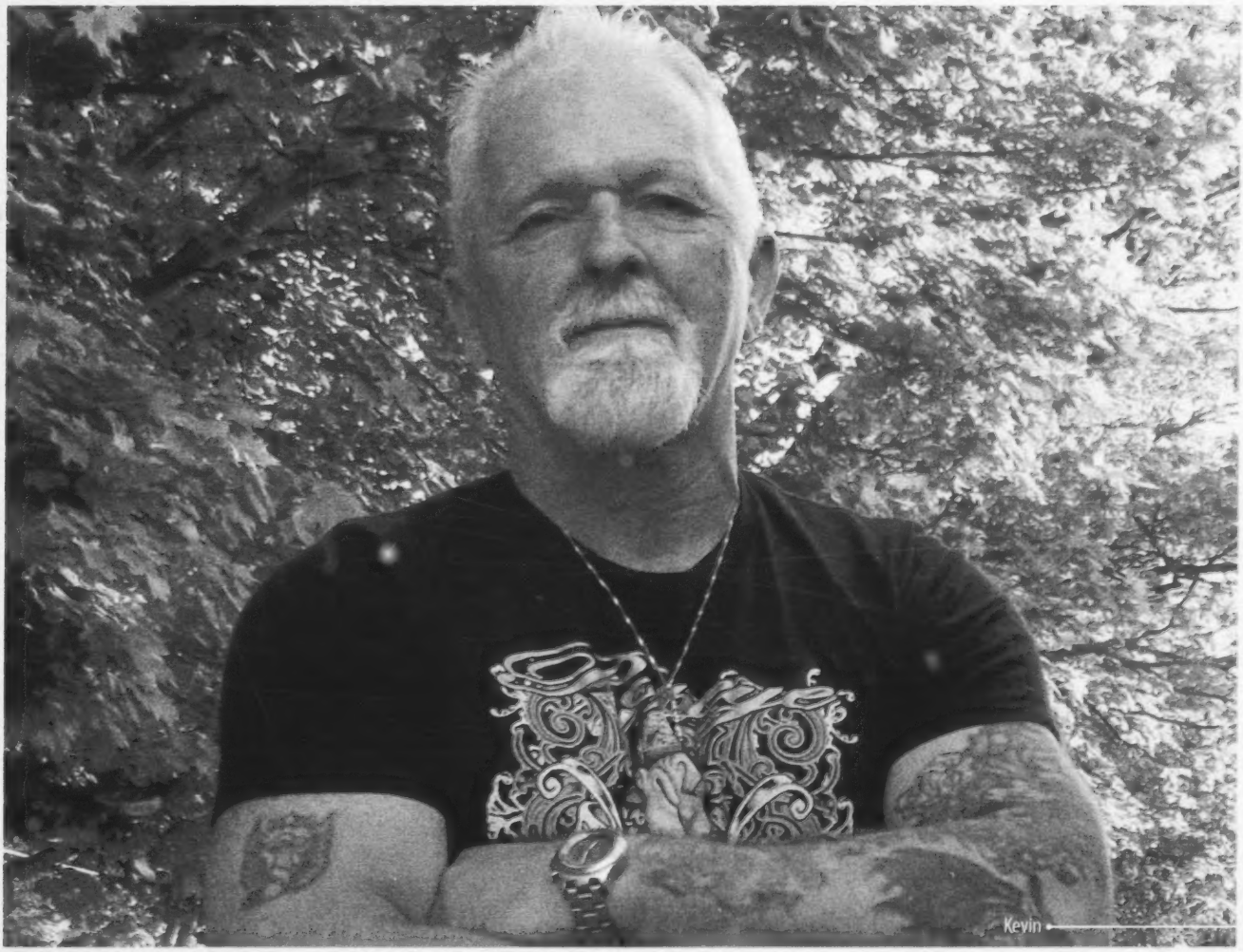
Kevin and Linda lived in North Wellington, just over an hour away from Guelph by car. His transition from hospital to palliative care happened during winter which meant poorer driving conditions for his wife, Linda. Transportation services, used to support patients, were not available to family members.

Linda was by his side as often as she could be but wanted to be there more. Both Carol and Linda knew about video technology that was often used to connect patients with care providers, education and specialists and thought; why not for families?

"When you're advocating for rural residents, it's about bringing care and services close to home," says Carol.

INNOVATION THROUGH TECHNOLOGY

As of 2016, 20 long-term care homes have been equipped to access video conferencing through the Ontario Telemedicine Network (OTN) to support the health of local residents.


Kevin

"This technology brought her to his bedside and – as far as I know – it's one of the first times we've used it for a family meeting."

Carol worked with the members of Kevin's care team at St. Joseph's Health Centre and with the help of a telemedicine nurse, they helped to arrange video visits with his family, through a computer unit that was brought to his room.

"It was really good," says Linda. "There was one day during the winter that I could just not get down to Guelph. Carol said; why don't we use the video system and his care team couldn't think of a reason why they couldn't. Everybody was so excited about it. We got to visit for as long as we liked and it really was just like I was in the room with him, sitting beside him."

Sadly, Kevin passed away that winter.

"We're fortunate to have telemedicine here," says Carol. "This was a real team effort to keep this family connected during a very unfortunate life circumstance. I don't know what they would have done without it."

CREATING A MORE SEAMLESS AND COORDINATED HEALTH CARE EXPERIENCE

A key aspect of providing a quality health system is ensuring residents get the right care, at the right place, at the right time. Easily navigating the health system is particularly important for those with the most complex health care needs.

Seamless care occurs when residents can easily transition from one area of care to another. A well-coordinated system means you don't have to repeat your story and you will know where to go to find the help you need.

IN 2015-16...

525

residents were assessed using a new tool that helps to identify seniors at risk of decline. These residents were referred to local community supports that will help keep them healthy and out of the hospital.

1,700+

seniors benefitted from expanded adult day programs last year.

#1

for the shortest wait time in Ontario for access to home and community care services (application from community setting - 13 days).

$17.1M

reinvested in hospital care through a reduction in the number of days residents spend in hospital waiting for care in a more appropriate place (ALC).

INNOVATION THROUGH EQUITY

Two Indigenous Wellness Conferences were attended by more than 200 residents, with additional opportunities for local First Nations, Métis and Inuit community members to attend a one hour, one-on-one session with a Traditional Healer.

INCREASING QUALITY OF LIFE FOR MORE WATERLOO WELLINGTON SENIORS THROUGH COMMUNITY SUPPORT CONNECTIONS

93-year-old Helen and her 92-year-old husband, Fred, have been attending Community Support Connections' free gentle exercise classes at their retirement home for the past two years. "We exercise as often as we can," says Helen. Married for 71 years, Helen and Fred hope to make it to their 75th wedding anniversary. One of the ways they intend to get there is by leading a healthy lifestyle.

The couple began attending SMART™ (Seniors Maintaining Active Roles Together) exercise classes shortly after they moved into their residence because Fred was told it would help prevent falls.

"It's pleasant to exercise with people you know in a group like that. The instructors have been very good. They are conscious of how everyone is doing and they watch for changes to make sure everyone is okay. I'm impressed with them!" said Helen.

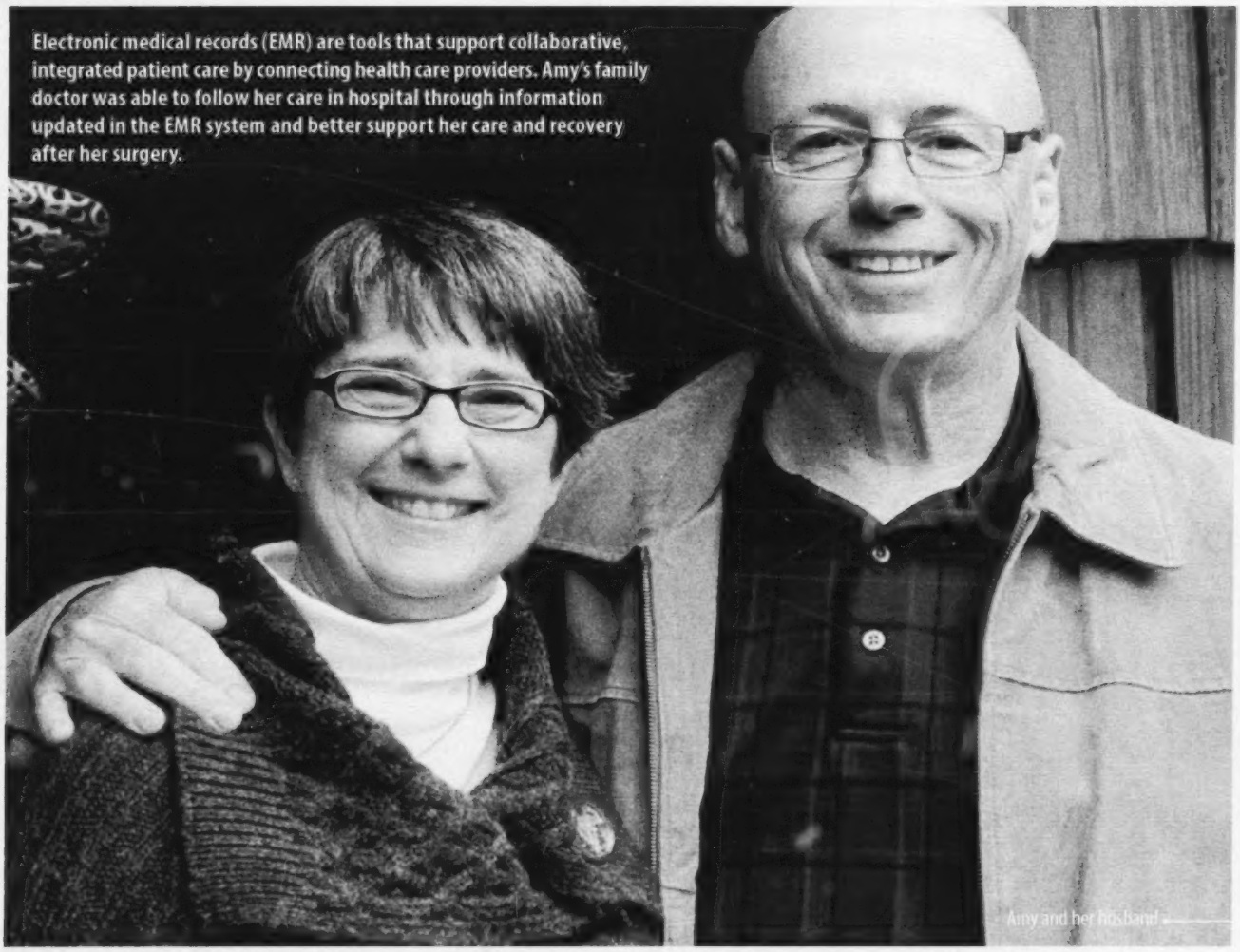
The classes have also inspired Helen and Fred to stay active throughout other parts of the day, including walking to the grocery store - a journey that can take up to a half an hour each way. Fred uses a walker to help him along and the couple stop and rest when they need to. But most importantly, they keep moving.

"If you don't use it, you lose it," says Helen. "It is keeping us in shape and it's something to look forward to every day."

The Waterloo Wellington LHIN began funding exercise and falls prevention classes at Community Support Connections – Meals on Wheels and More (CSC) in late 2013. The program has been a great success and is very popular with local seniors.

In 2015, as part of the health system's ongoing commitment to ensure equitable access to health services, an opportunity was identified to support local French speaking seniors by providing exercise classes in French. In partnership with the Centre communautaire francophone de Cambridge, CSC collaborated with the Centre in securing bilingual gentle exercise facilitators and were able to commence French language gentle exercise classes in February of 2016.

"CSC was delighted to partner with the Centre communautaire francophone de Cambridge to provide this service. It aligns with our strategic priorities of community engagement, responsiveness and exceptional client experience."
- Jenn McDonald, Exercise and Falls Prevention Coordinator



Electronic medical records (EMR) are tools that support collaborative, integrated patient care by connecting health care providers. Amy's family doctor was able to follow her care in hospital through information updated in the EMR system and better support her care and recovery after her surgery.

Amy and her husband

PUTTING PATIENTS FIRST: EXPERIENCING SEAMLESS CARE ACROSS PROVIDERS

It was a few days before Christmas when Amy first started feeling ill. Sick to her stomach and experiencing pain on one side, her husband convinced her to call her family doctor for help.

"It just didn't get better," says Amy. "I felt worse and worse. I didn't know if anyone at my doctor's office would be able to fit me in so close to Christmas but they did. They got me in that afternoon."

Amy arrived at the Guelph Family Health Team that day to see the nurse practitioner (NP). When a routine examination could not confirm what was wrong, her NP decided to order an ultrasound to help identify the source of Amy's pain.

"It was four days before Christmas and many offices were closed," Amy explains. "I don't know how many phone calls they made but I know they called a lot of different places to get me that ultrasound. When I mentioned that I lived in Erin, they thought they could try the Fergus hospital which is close to me."

Less than two days later, Amy's ultrasound at Groves Memorial Hospital in Fergus showed that she had gallstones and needed surgery, results that were

shared electronically with her family doctor. A referral to a Guelph area surgeon was made that same day which provided both relief and disappointment for Amy and her husband.

"My doctor's office called me right away to let me know. I was so glad to truly know what was happening to me – it meant that I didn't have to spend my Christmas holidays worrying about what it could be," says Amy. "But at the same time, it meant that we were probably going to have to cancel our trip to Florida. A physician at my family doctor's office took the time to meet with us to discuss the risks, and we decided together that travel outside of the country would be too risky for my health."

Amy's surgery was booked for March 30th but it actually happened on February 12th. As a retiree with a flexible schedule, Amy was able to take an earlier appointment, available after another patient cancelled. Having surgery as soon as possible was a priority for Amy.

"I had the surgery and everything went very well," says Amy. "Everyone was so accommodating and reassuring. I remember when gallbladder surgery was a very huge procedure, but I was home in my own bed by 6:30 pm that evening. It was a very easy recovery."

Amy credits an integrated health system with her positive experience.

"My experience is a great example of when the system works well. In my case, it all worked together really smoothly. My doctor's office called me right away with results of my ultrasound and everyone worked together to get me the care I needed. Look at how many different practitioners were involved and how smoothly it went. In Ontario, we're very fortunate to have the quality of health care that we have. It's pretty amazing."

THEN (2013)

72% of primary care doctors were using Electronic Medical Records.

NOW (2015)

Nearly 90% of primary care doctors are now using an Electronic Medical Record

MINTO RURAL HEALTH CENTRE OPENS TO PROVIDE RURAL RESIDENTS WITH COORDINATED CARE

After five years of planning, the Minto Rural Health Centre opened its doors to residents in spring 2016 to provide increased access to integrated and coordinated care. Residents can now go to one central location to receive primary care, mental health and addictions support, wound care and support through the Community Care Access Centre.

"This is a great example of how integrated health models can support better health outcomes for rural residents," says Waterloo Wellington LHIN Board Chair Joan Fisk. "Residents will benefit from a number of health services all located centrally, and working in partnership to support the continuum of care. This is the type of collaboration that will build a strong foundation for improved health and wellness for years to come."

The Waterloo Wellington LHIN has equipped the new centre with video-conferencing technology that will help care providers and residents connect with other centres and care providers for education, consultation, assessments and follow up care, close to home.

To achieve our objective of creating a more seamless and coordinated health care experience, the following initiatives were undertaken with health professionals across Waterloo Wellington:

INTEGRATING SERVICES TO IMPROVE EXPERIENCE AND HEALTH OUTCOMES BY STREAMLINING ACCESS TO SIMILAR TYPES OF CARE AND SERVICES (HORIZONTAL INTEGRATION); COORDINATING ACCESS ACROSS ORGANIZATIONS INVOLVED IN THE HEALTH CARE JOURNEY

COMMUNITY CARE

INITIATIVE

- Establish efficient and integrated personal support service delivery for residents in the community.
- Improve health outcomes and experience for residents by increasing timely access to equitable and integrated community services.

ACCOMPLISHMENT

- The second year of a three-year investment to increase personal support worker pay for community providers was implemented. This provincial initiative aims to ensure community PSWs are paid at minimum $16.50 per hour.

SENIORS CARE

INITIATIVE

- Continue to improve care for seniors through effective assess and restore services, dementia and Alzheimer strategies, and by improving access to specialized geriatric services.

ACCOMPLISHMENT

Waterloo Wellington is home to world class aging innovation hubs:

- The Research Institute for Aging (RIA) in Waterloo Region opened in 2015 and aims to be one of the top five innovation institutes for aging in the world. The Institute is a partnership between Schlegel Villages, University of Waterloo and Conestoga College.
- The RIA is associated with the Schlegel Centre for Learning, Research and Innovation in Long-Term Care (CLRI) which has real-life classrooms with simulations to provide health care providers with research-informed practice change and care innovations.
- Waterloo Wellington is home to innovative memory clinics – developed locally and being implemented internationally:
  - There have been 1,715 memory assessments completed through the Centre for Family Medicine (CFFM) Memory Clinic since inception in 2006, serving 614 residents with memory loss.
- A new exercise program was established for French speaking seniors through Community Support Connections – Meals on Wheels and More. French speaking residents can access these community services that keep them fit and help to prevent injuries from falls.
- Since 2013, 7,573 residents have been referred for specialized geriatric services. Wait times for these services have been reduced from approximately five months to 4-6 weeks thanks to collaboration, integration, investments in geriatric nurse practitioners, memory clinics, and a clinical intake service that has increased efficiency and improved the patient experience.
- Local hospital emergency departments are now using short one-page assessments for seniors to identify residents who would benefit from additional help in their home.

PATIENT TRANSITIONS

INITIATIVE

- Improve patient experience and flow for patients through integrated discharge and patient transition practices.

ACCOMPLISHMENT

- All hospitals have implemented an improved discharge planning experience for residents.

- More than 93% of residents needing home care following a hospital stay receive their first service within five days.
- Through collaboration across health service providers, strategies and communications tools have been put in place that improve the discharge process from hospital to long-term care.
- Residents in Waterloo Wellington have some of the shortest wait times for long-term care in Ontario (2nd shortest from hospital and 5th shortest from home).
- A Patient Transitions Dashboard that tracks any upcoming patient transitions for providers has been created and shared across the system. As a result, care providers are better able to share best practices and strategies for successful patient transfers.

ALTERNATE LEVEL OF CARE

INITIATIVE

- Remove barriers for people waiting for care in another area of the health system (alternate level of care or ALC).

ACCOMPLISHMENT

- The number of days residents spend in hospital waiting for care in a more appropriate place has been cut by more than 50% since 2009 (25.9% ALC Days in 2009 to 12.19%).
- In 2015-16, 1,969 hospital ALC days were saved through a reduction in the ALC rate.
- Since the implementation of Home First in 2011, 38,183 hospital ALC days have been saved resulting in $17.1M being re-invested into hospital care.

As a result of the Integrated Stroke Program, the Ontario Stroke Network has recognized Waterloo Wellington as having the most improved stroke program in the province.

"Sarah's situation was critical. By the time she got to Community Care Concepts, she had exhausted all other options."

- Karla, Community Outreach Coordinator with Community Care Concepts (CCC)

CULTURALLY APPROPRIATE CARE MAKING A DIFFERENCE

Sarah's situation was critical. By the time she got to Community Care Concepts, she had exhausted all other options. Previous contact with community and government supports resulted in Sarah's children being removed from her home which left her distrustful of others.

"Sarah has very severe obsessive compulsive disorder," explains Karla, Community Outreach Coordinator with Community Care Concepts (CCC). "She was referred to us through a Community of Practice meeting. This is where a number of different health practitioners and community workers from different organizations meet to discuss cases that are not progressing. We're careful to protect patient privacy but it does give us a great opportunity to collaborate and share new ideas that may help each other's clients."

Obsessive compulsive disorder is a mental illness that causes unwanted and repetitive thoughts, urges or images that don't go away (obsessions) and actions that are meant to reduce the anxiety brought on by the obsessions (compulsions). Some people have obsessions, some have just compulsions and some like Sarah, have both.

As a member of the Mennonite community, many aspects of Sarah's life, including her health, are intertwined with wider cultural and religious beliefs. Mental illnesses are sometimes not recognized as a health issue. These cultural and religious considerations can make traditional health care methods less effective and the family's attempts to support Sarah were not achieving a lot of success.

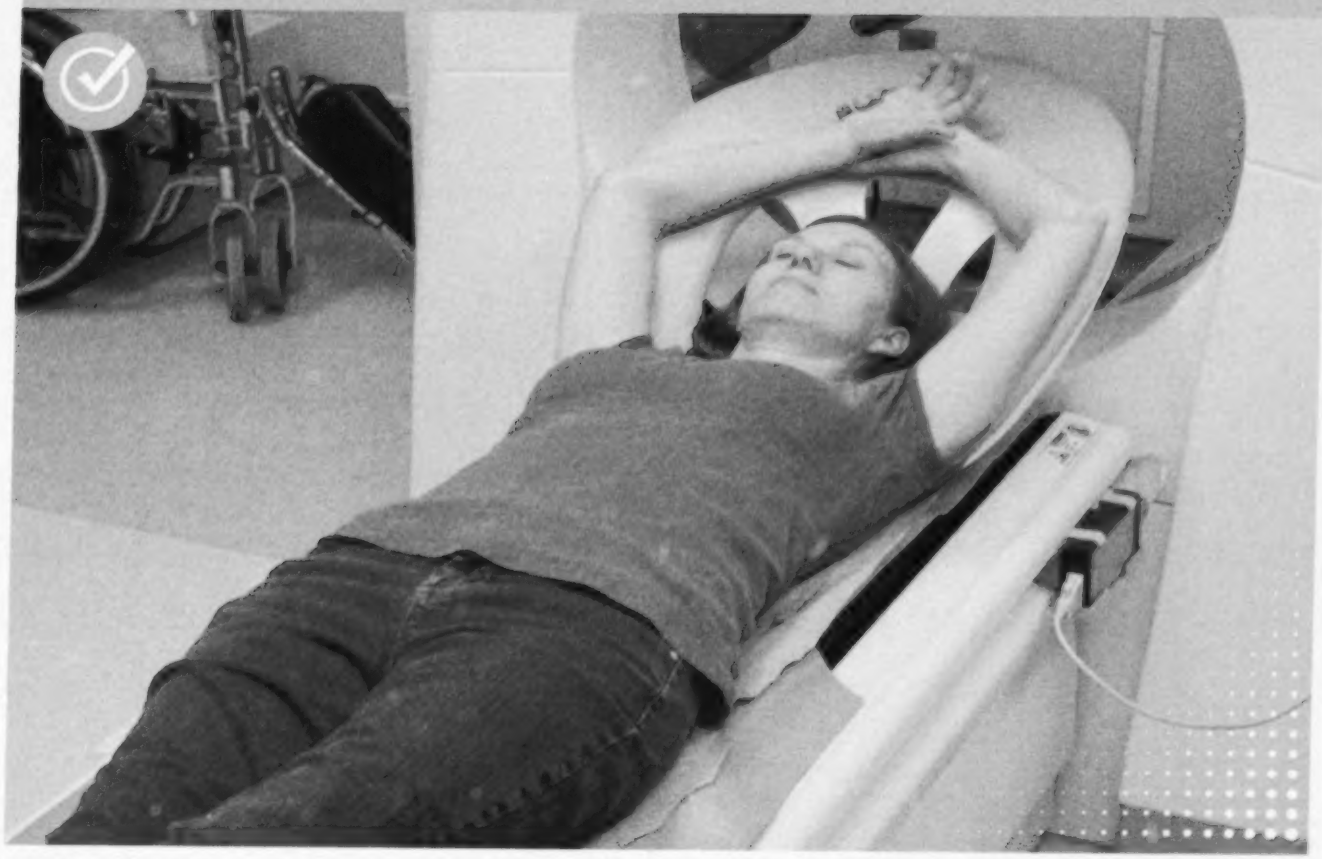
It seemed there was no other way to help her. But when her case was presented, other possible solutions were identified. Members agreed that Sarah's home environment needed support and that CCC's programs might have success by incorporating an approach that centred more around Sarah's culture and family connections.

"It took time to build trust between us," explains Karla. "The Mennonite culture is not very trusting of "outside" people, professional or not. Once we had an entire meeting through an open window on the front porch in the middle of winter, she inside and me outside. But we try to meet people where they are at, and Sarah has been making progress."

Karla also met with Sarah's family to advocate for her and help to build practical strategies that worked for everyone, grounded within their strong Mennonite culture. This has also helped her family to better understand her illness.

"I think that if this work has taught me anything, it's that we can all find ways to be flexible and creative to help our clients reach their goals," says Karla. "Culture, religion and personal preferences and experiences are huge a part of who we are and they can be part of our solutions too."

LEADING A QUALITY HEALTH CARE SYSTEM USING EVIDENCE BASED PRACTICE



Having access to quality care means that your care is safe, effective, accessible, equitable, efficient, integrated and focused on prevention as much as treating illness.

The best way to ensure our services meet those standards is to base our care off of proven methods and ensure those methods are used consistently across the system.

IN 2015-16...

2,800+

residents have received advance care planning resources through Advance Care Planning Waterloo Wellington.

99%

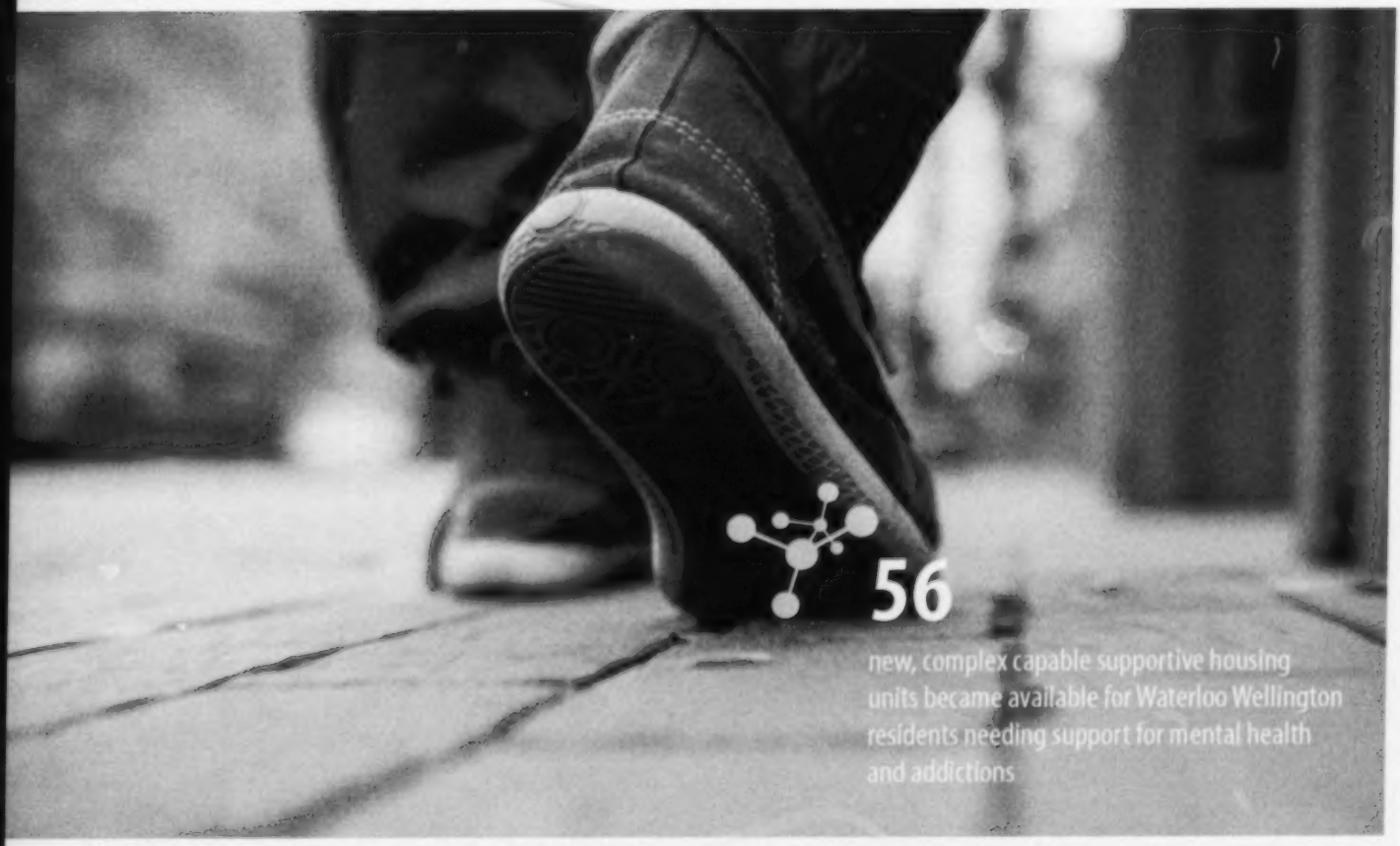
of residents receive timely access to cardiac bypass surgery (within target).

54%

more long-term care beds in the City of Waterloo through the opening of The Village at University Gates.

978,360

fewer hours spent in Waterloo Wellington Emergency Departments (ED) with patient flow improvements since April 2008 (when ED wait times were first measured).


56
new, complex capable supportive housing units became available for Waterloo Wellington residents needing support for mental health and addictions

EXTRAORDINARY NEEDS PROGRAM FINDS PHILIP A PLACE TO BELONG

If it weren't for the Extraordinary Needs Program (ENP), Philip might still be in the hospital today. By the time he got to the ENP, he had already spent a total of 424 days as an inpatient in hospital, and a significant amount of time in other facilities to help him cope with a dual diagnosis, disrupted sleep patterns, limited attention span, and difficulty managing activities of daily living on his own. A dual diagnosis usually means that a person has a mental disability at the same time as they are managing a mental illness.

He attended day programs at the hospital each week but was unable to find the intensive one-on-one care and support that he needed to experience the quality of life that he was capable and deserving of. Philip's family was worried he would never have a place that he truly belonged.

Then staff from the Extraordinary Needs Program (ENP) entered his life. The ENP provides dedicated individualized supports to individuals with complex mental health and other needs to live in a community

Residents seeking emergency mental health or addictions care in Guelph Wellington are benefiting from care improvements as a result of a full review and recommendations to improve these services. Last year residents needing emergency mental health and addictions care spent a total of 5,252 less hours in the emergency department.

setting. The program helps many residents that are considered Alternate Level of Care; patients who no longer need care in hospital but still need support to live in the community or care at another facility. In Philip's case, he could not be safely discharged from the hospital without having additional community supports.

The ENP staff worked with Philip to create a plan that would see him connected to one-on-one support and helped him transition to community-based living in a group home.

"When Philip arrived, he was withdrawn," explains his worker. "It took him a while to get used to it. He was skeptical of staff and very wary of the intentions of the other housemates. But now, he's completely different. He's been decorating his bedroom and has three bulletin boards full of pictures of his family, roommates, and of many of the outings he's enjoyed."

As Philip has improved, his need for one-on-one support has decreased. He enjoys scheduling and completing daily tasks and has developed trust in the staff that care for him.

Without the ENP, Philip might still be spending his days in a hospital. While his journey is just beginning, Philip has found friends, a quality of life and a place where he belongs – he has finally come home.

SECURE ACCESS TO PATIENT'S DIGITAL HEALTH INFORMATION SUPPORTS TIMELY CARE

To provide high quality and timely care, the health care professionals at the Village of Winston Park in Kitchener need to frequently access their residents' medical information. Traditionally, this meant making endless calls and submitting formal requests for information to understand the 'big picture' of their residents' care needs. This has all changed since they gained access to the cSWO Regional Clinical Viewer, ClinicalConnectTM, a secure, web-based portal that enables doctors and clinicians to talk to one another and share patient information electronically.

Barb Sutcliffe is a registered nurse and the Memory Clinic Team Lead at Winston Park. She noted that they can now source the relevant details and medical documents relating to the residents' health history easily and seamlessly.

"We were preparing in Memory Clinic for one of our clients and realized the CAT scan results we requested had not been forwarded by the family doctor. We were able to pull up the results on ClinicalConnect, which aided in our discussion to determine a diagnosis for our client, and this saved him having to book another appointment while we waited for his results. This is a win-win for us and the client."

The connecting South West Ontario (cSWO) Program is part of eHealth Ontario's Connecting Ontario initiative, which is enabling systems to talk to each other in order to get secure, accurate and comprehensive patient information into the hands of health care providers as quickly as possible. In Waterloo Wellington, the cSWO Program delivery partner at the Centre for Family Medicine Family Health Team eHealth Centre of Excellence, which deployed Clinical-Connect at Winston Park, works with physicians and health care professionals at hospitals, long-term care homes, the CCAC, physician offices and other health care organizations to deploy ehealth solutions.

Local health care providers are now able to securely access their patient's electronic health information from all acute care hospital sites, Community Care Access Centres (CCACs) and Oncology Centres in south west Ontario, plus two provincial data repositories for lab and diagnostic imaging tests and results.

To achieve our objective of leading a quality health care system using evidence based practice, the following initiatives were undertaken with health professionals across Waterloo Wellington:

IMPLEMENT EVIDENCE-BASED PRACTICES TO ENSURE THE SAME HIGH-QUALITY STANDARD OF CARE IS PROVIDED ACROSS ALL SITES FOR SIMILAR SERVICES.

QUALITY IMPROVEMENT

INITIATIVE

- Accelerate best practice care through the system-wide adoption of electronic clinical order sets for Quality Based Procedures.
- Enhance quality and ensure delivery of best practice through current integrated programs and new integrated programs.

ACCOMPLISHMENT

- All residents who have been to local hospitals can expect their hospital information will now be electronically forwarded to their primary care provider. 400 of our local 600 primary care providers, are set up to receive hospital patient information electronically.
- Electronic Clinical Order Sets were launched in the first quarter of the year. These ensure that all patients with similar health needs receive the same, high-quality, best practice care at all area hospitals.

EXPAND AND ENHANCE INTEGRATED PROGRAMS THAT ENSURE QUALITY AND DELIVER BEST PRACTICE CARE ACROSS THE CONTINUUM OF CARE. KEY IMPROVEMENTS WILL INCLUDE:

PALLIATIVE CARE

INITIATIVE

- Improve the end-of-life experience for palliative residents and their families by ensuring there are options for people to die in the place of their choice.
- Support advanced care planning processes across the continuum of care and throughout the community.

ACCOMPLISHMENT

- More than 2,800 people were engaged in a regional Advance Care Planning initiative aimed at improving end-of-life care for local residents. Today, 85.7% of palliative patients in Waterloo Wellington are able to pass away in the place of their choice – an increase of 8% since December of 2014.
- Residents in long-term care are benefiting from increased staff education in managing pain and end-of life symptoms. Local long-term care homes manage pain more effectively than the provincial and national averages.

LONG TERM CARE (LTC)

INITIATIVE

- Improve the quality and safety of care in LTC Homes.

ACCOMPLISHMENT

- Residents in Waterloo Wellington receive higher quality care in LTC than the provincial and national averages, related to potentially unnecessary antipsychotic drug use, restraint use, and pain management.
- Two Nurse Practitioners were funded to work out of four Wellington County LTC homes to provide more efficient and coordinated care to residents.
- Waterloo Wellington long-term care homes have the lowest number of residents needing emergency department care in Ontario (5.6%).

EMERGENCY DEPARTMENT (ED)

INITIATIVE

- Continue implementation of best-practices in ED care.
- Improve care and experience for mental health and addictions patients

ACCOMPLISHMENT

- Residents have waited 978,360 fewer hours in the ED with patient flow improvements since April 2008 (when ED wait times were first measured).
- Residents with complex needs in local emergency departments were seen and sent home or admitted to a hospital bed within 8 hours. The Waterloo Wellington LHIN met the provincial target, sharing the top result in the province.
- Residents in Waterloo Wellington who visited an ED and required admission to hospital spent the least amount of time in the ED in the province. The length of stay for admitted patients is 18.2 hours compared to 28.1 hours provincially.

MENTAL HEALTH AND ADDICTIONS

INITIATIVE

- Ensure all residents have access to complex capable services at the right time, in the right place.
- Improve access to intensive mental health services including optimizing Assertive Community Treatment Teams and support coordination.
- Expand availability of mental health and addiction supports in housing.

ACCOMPLISHMENT

- 56 new complex capable supportive housing beds were created in Waterloo Wellington. This means that residents with both mental health and addictions concerns can be better supported.
- Residents needing emergency mental health care are waiting 83% less time for care as a result of a full review of emergency mental health services in Guelph and Wellington completed in early 2016. The review resulted in a series of recommendations - many have been implemented and others will be implemented throughout 2016.

PHARMACY

INITIATIVE

- Implement protocols for anti-microbial stewardship.

ACCOMPLISHMENT

- An anti-microbial stewardship committee was launched early in the year to ensure safe practices around, and prevent the overuse of antibiotics across the region.
- 5 Waterloo Wellington pharmacists were trained by the Harvard School of Medicine in anti-microbial stewardship and an educational event was held for pharmacists, physicians and hospital staff.

DIAGNOSTIC IMAGING

INITIATIVE

- Reduce duplicate diagnostic imaging procedures.
- Reduce wait times for diagnostic imaging procedures by optimizing service delivery models.

ACCOMPLISHMENT

- Provincially, the Waterloo Wellington LHIN has the highest demand per operating hour in MRI and is the most efficient in serving the highest number of

We have some of the most effective hospitals in Ontario. Our rate of readmissions to hospital is the lowest in the province for residents requiring major surgery or who have had a heart attack (a measure of high quality care).

residents per funded operating hour. 38,767 adults received MRIs in Waterloo Wellington last year, an increase of 7.5%.

- 82.7% of residents receive their CT scan within the provincial access targets, compared with 74.6% provincially. 33,953 adults in Waterloo Wellington received CT scans last year.

CRITICAL CARE

INITIATIVE

- Implement standardized clinical protocols and intensive care unit best-practice design.
- Develop and implement long-term ventilation program standards.

ACCOMPLISHMENT

- Residents are receiving more consistent care across providers as a result of the ICU high performing checklist being implemented in all Intensive Care Units to ensure best practice across Waterloo Wellington.

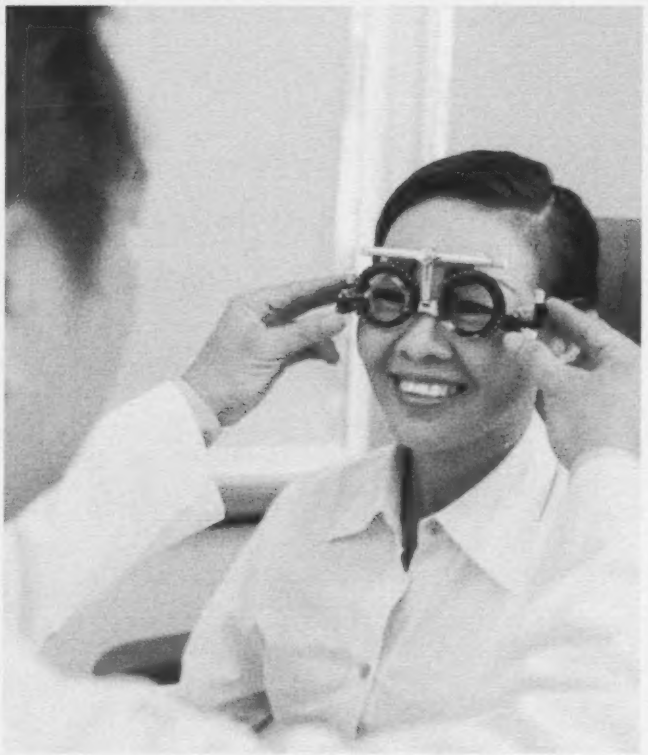
SURGERY

INITIATIVE

- Improve access to specialized vision (eye) care and promote a seamless eye care experience by strengthening the relationships between primary care, ophthalmology, and optometry.

ACCOMPLISHMENT

- In the spring of 2014, University of Waterloo launched a Vision Centre of Excellence. This local planning group, including hospitals, schools, specialists, and the Waterloo Wellington LHIN will identify gaps and barriers to better care, improve collaboration, and develop recommendations for improving access to care.



SHORTER WAIT TIMES	IMPROVED BY*
Emergency department stay for admitted patients: Down 47.9%	**13.9** HRS
Non-urgent MRIs: Down: 66.1%	**148** DAYS
Non-urgent CT scans: Down: 76.5%	**101** DAYS
Hip replacements: Down: 47.1%	**197** DAYS
Knee replacements: Down: 43.8%	**216** DAYS
Cardiac by-pass surgery: Down 82.2%	**120** DAYS

*This reflects improvements from the system starting point, i.e. when measurement started.

To learn more about the 2016-19 IHSP, 2016-17 Annual Business Plan or to read more stories from our local residents, visit wwlhin.on.ca.

LOOKING FORWARD

As we reflect on the progress we have made over the past three years, we are also looking forward to the work that still needs to be done.

In February of 2016, we released our next Integrated Health Service Plan (IHSP). The 2016-19 IHSP directly reflects the needs of local residents, health service providers and other community leaders through extensive engagement. The objectives outlined in the plan align with the provincial direction for health care but also reflect the unique health care needs of our local population. You told us what health services were important to you and your family and we listened.

Each year, we will develop an Annual Business Plan that outlines specific actions that will be taken across the health system to achieve the objectives set in the IHSP. We heard you say that increased access to primary care, improving home and community care and a continued focus on health quality are important to you. In the coming year, those areas will be a significant focus of our work. To our partners, thank you for your ongoing commitment to improving the health and well-being of our families, friends and neighbours.

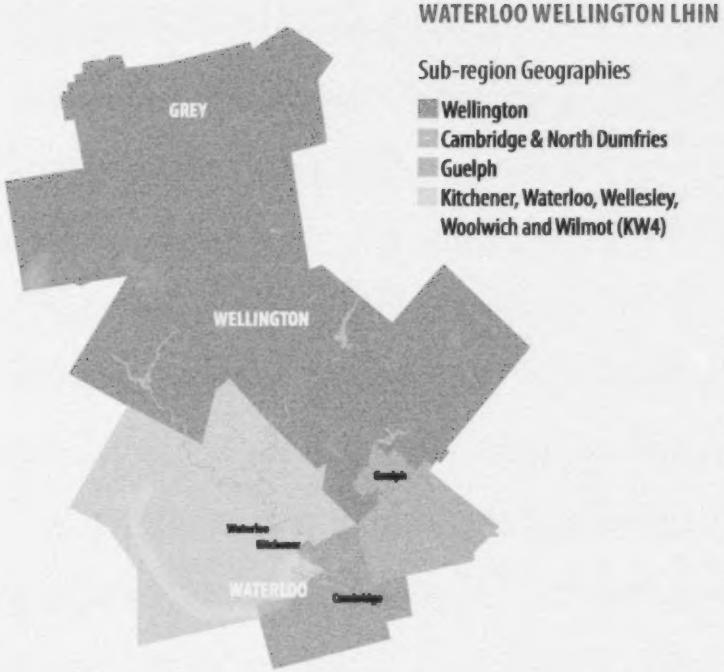
The 2016-19 IHSP focuses our work on four priority areas that will result in better health outcomes for resident and a stronger health system:

ACCESS - Provide faster access to the right care.

CONNECT - Deliver better coordinated and integrated care in the community, closer to home.

INFORM - Support people and patients – providing the education, information and transparency Ontarians need to make the right decisions about their health.

PROTECT - Protect our universal public health care system – making evidence based decisions on value and quality, to sustain the system for generations to come.



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